

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2012
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-M/			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments Complaint investigation #28759, #29118, #29425, #28897, and #29797, were completed on May 24, 2012. nno deficiencies were cited with Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

LKCF11

If continuation sheet 1 of 1